Medical Information Form

The Medical Information Form must be completed in its entirety. This form must be received before the application can be processed and approved.

Parent/Guardian of Wig Applicant please complete this section

Applicant Name _____

Address _____

City _____ **State** _____ **Zip** _____

Phone (_____) _____ – _____ **Email Address** _____

PARENT/GUARDIAN of WIG APPLICANT STOP HERE
THE REMAINDER OF THIS FORM MUST BE COMPLETED BY A MEDICAL PROFESSIONAL

MEDICAL INFORMATION

Are you the Primary Medical Contact for the Wig Applicant? ☐ Yes ☐ No

Organization or Hospital Name_____

Address _____

City _____ **State** _____ **Zip**_____

Phone (_____) _____ – _____ **Email Address**_____

By signing this Medical Information Form as a medical professional, I hereby acknowledge and affirm that the above wig applicant has a medical need for a prosthetic device for the following reason:

☐Alopecia ☐Cancer ☐Trichotillomania ☐Burns ☐Other Must Specify: _____

Your Printed Name _____

Your Signature _____ **Date** _____/_____/_____

Please return this completed form to the Parent/Guardian of Wig Applicant.

INSTRUCTIONS FOR PARENT/GUARDIAN OF WIG APPLICANT

Return all 4 items on the checklist below to Wigs for Kids at the address listed below:

1. Current color picture of applicant showing areas of hair loss
2. Color picture of applicant prior to hair loss or preferred wig style
3. One Legal Age Document Copy- Birth Certificate, Passport, Visa, State Issued ID, or Valid Driver License
4. This completed Medical Information Form

Wigs For Kids
ATTN: Recipient Department
24231 Center Ridge Road • Westlake, Ohio 44145